AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/10/2012			
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE  LESLEY AVE				
ROSEWA	ALK VILLAGE AT I	NDIANAPOLIS	INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F0000		,						
	Complaints II IN00117665.  Complaint IN Substantiated deficiencies r allegations ar F309.  Complaint IN Substantiated related to the Survey dates: October 9 &	elated to the e cited at F157 and 100117665  No deficiencies allegation is cited. 10, 2012	F0000	The creation and submission this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of crediballegation and requests a Desireview on or after 10/18/2012	ot s t n of le k			
	Facility number Provider number 1							
	AIM number	: 100274950						
	Survey Team Mary Jane G.							
	Census bed ty SNF: 8 SNF/NF: 134 Total: 142							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4Y3R11

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  OF CORRECTION  155329	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 0/2012		
	PROVIDER OR SUPPLIER  ALK VILLAGE AT INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE  1302 N LESLEY AVE INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	Census payor type: Medicare: 39 Medicaid: 79 Other: 24 Total: 142 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/10/12 Cathy Emswiller RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4Y3R11

Facility ID: 000222

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155329	B. WING			10/10/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			LESLEY AVE		
ROSEWA	ALK VILLAGE AT IN	IDIANAPOLIS			APOLIS, IN 46219		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157 SS=D	resident; consult physician; and if I legal representation member when the the resident which the potential for reintervention; a signesident's physical status (i.e., a deteor psychosocial sthreatening condicomplications); a significantly (i.e., existing form of the consequences, of treatment); or a discharge the resident and, if know the facility must a resident and, if know the there is a commate assign §483.15(e)(2); or under Federal or	ME/ROOM, ETC) mediately inform the with the resident's known, notify the resident's ve or an interested family ere is an accident involving the results in injury and has equiring physician gnificant change in the fall, mental, or psychosocial erioration in health, mental, tatus in either life tions or clinical need to alter treatment a need to discontinue an reatment due to adverse or to commence a new form a decision to transfer or dident from the facility as also promptly notify the mown, the resident's legal interested family member					
	update the addre- the resident's leg- interested family						
	Based on reco	rd review and	F01:	57	F157 Notify of changes		10/18/2012
	interview the facility failed to			(injury/decline/room, etc) It is the practice of this provider to ensure that all alleged violations			
	ensure immed	iate notification, in			J	าร	
	that when a re	sident fell and			involving Notify of changes (injury/decline/room, etc) are		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4Y3R11

Facility ID: 000222

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED
		155329	B. WIN			10/10/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	ę.		1302 N	LESLEY AVE	
	ALK VILLAGE AT IN	NDIANAPOLIS		INDIAN	APOLIS, IN 46219	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	provided in accordance with S	DATE
		acture, the nursing			and Federal law through	late
	staff failed to immediately notify				established procedures. What	
	the resident's	physician of the			corrective action(s) will be	
	results of the x-ray for possible				taken for those residents fou	nd
		and also failed to			to have been affected by the	ant
	· ·				deficient practice? The reside no longer resides in the facility	
	notify an interested family member of the condition of the resident for 1 of 3 recently admitted resident's				How will you identify other	•
					residents having the potentia	al
					to be affected by the same	
	reviewed for a	assessment and falls			deficient practice and what	
	in a sample of	7. [Resident "A"].			corrective action will be take All residents who reside in the	
		7. [Resident 11].			facility have the potential to be	
	1				affected by the alleged deficien	
	Findings inclu	ıde:			practice. All licensed nurses v	
					be re-educated on MD and far	
	The record for	r Resident "A" was			notification of change in condit timeliness of notification, and f	
	reviewed on 1	0-09-12 at 11:30 a.m.			machine check frequency by t	
		eluded but were not			SDC or designee by 10/18/12	
					What measures will be put	
		iculty in walking,			into place or what systemic	
	lymphedema,	osteoarthritis, pain in			changes will you make to ensure that the deficient	
	joints (ankle a	and feet), and sleep			practice does not recur? All	
	apnea. These	diagnoses remained			licensed nurses will be	
	*	time of the record			re-educated on MD and family	
	review.	mic of the feeding			notification of change in condit	
	Teview.				timeliness of notification, and f machine check frequency by the	
					SDC or designee by 10/18/12	
	The record inc	dicated the resident			The facility will in-service nursi	ing
	was admitted	to the facility on			and nurse management staff of	
	09-24-12.	-			fax machine document review	
	· · · · · · · · · · · · · · · · · · ·				Licensed nurses will be require to complete hourly checks of the	
	A: 0.4	D N			fax machine to monitor for any	
		ne Progress Notes			x-ray results requesting family	
	dated 09-24-1	2 for 11:00 p.m.			and physician notification. DN	S
			1			

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Event ID: 4Y3R11

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If continuation sheet Page 4 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			ì '	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155329	B. WIN	G		10/10/2012	
ROSEWA	PROVIDER OR SUPPLIER	IDIANAPOLIS		1302 N INDIAN	ADDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  and IDT will review clinical	(X5) COMPLETION DATE	
	"Writer found the floor next happened says to get to go us fell on the floor motion] is Whimits] to both extremity, west to lower extremassessed and redenies hitting assisted back to assist. Completime. MD [M notified and x light is within to monitor."  The record incompleting assisted back to assist. Completime and x light is within to monitor."	resident sitting on to bed, asked what s [resident] was trying e the bathroom and or. ROM [range of NL [within normal upper and lower akness and discomfort mity. Resident to injury at this time, head. Resident to bed with three staff ain of hip pain at this edical Doctor] rays ordered. Call reach, will continue dicated the local area company came to the enformed the x-ray as			and IDT will review clinical records to ensure family and physician notification of any significant change Monday through Friday. The weekend supervisors will perform this review on Saturday and Sunda How the corrective action(s) will be monitored to ensure the deficient practice will not recite. What quality assurance program will be put into place Physician/family notification Columbiated audit tool will be completed on weekly x4, bi-weekly x2, and the monthly thereafter by the DNS designee. Physician/family notification CQI audit tool will be reviewed monthly by the CQI Committee for 6 months after which the CQI team will re-evaluate the continued need for the audit. If threshold of 95 is not achieved an action plan be developed to ensure complianceDeficiency in this practice will result in disciplinate action up to and including termination of the responsible employee. Date of Compliance 10/18/12	he ur, e? QI ce nen or be	
	09-23-12 and	faxed [facsimile] to					

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Event ID: 4Y3R11

Facility ID: 000222

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/10/	ETED
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE LESLEY AVE APOLIS, IN 46219		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	3	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		DATE
	1	2:37 a.m., indicated				
	_	obese pt. [patient] left antric fracture of the				
	left femur."	antire fracture of the				
		er the nurse received				
		the x-ray the nurse				
	clinical record	following in the				
	6:37 a.m. [date 7:41 a.m.], income results of the and orders give	s, dated 09-25-12 at e created 09-25-12 at dicated MD updated the "L" [left] hip x-ray ren to send patient to gency room] for				
	7:00 a.m. [dat 7:42 a.m.], inc family member	s, dated 09-25-12 at e created 09-25-12 at dicated "[Name of er] called and updated tatus and being the ER for				
	a concerned fa	10-09-12 at 8:22 a.m. amily member esident] had been in				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329		LDING	NSTRUCTION  00	(X3) DATE COMPL 10/10/	ETED
NAME OF F	PROVIDER OR SUPPLIER		D. WIIV		DDRESS, CITY, STATE, ZIP CODE		
	ALK VILLAGE AT IN				LESLEY AVE APOLIS, IN 46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	AI OLIO, IIV 40219		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		reviously and was					
		all risk. When					
		admitted [resident]					
		d the floors were					
		re assured someone					
		lable to help with					
		athroom and that sort					
	of thing and someone would be						
	with [resident] at all times.						
	[Resident] said the fall occurred						
	· · · · · · · · · · · · · · · · · · ·	p.m. or 11:45 p.m. the					
	_	ion. [Resident]					
		lent] head and broke					
		They didn't call me					
	until the next	•					
		already transferred to					
	the hospital."						
l	Interview on 1	0-10-12 at 10:45					
	a.m. the Direc	tor of Nurses					
		esident] fell and					
	_	own responsible					
		essment was done and					
	the resident ha						
		he nurse [licensed					
		e employee #8]					
	*	octor and got an order					
		Range of Motion was					
		ything was within					

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Event ID: 4Y3R11

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329		LDING	NSTRUCTION  00	(X3) DATE COMPI 10/10	
	PROVIDER OR SUPPLIER		p. WIIV	STREET A 1302 N	DDRESS, CITY, STATE, ZIP COD LESLEY AVE APOLIS, IN 46219	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	normal limits. the family men of his shift."  Review of the 10-10-12 at 9: "Resident Charand dated as reconstructed and dated as reconstructed in POLICY [box policy of this that appropriate effective inter"  "PROCEDUR Change - a. A change in a reconstructed by	The nurse notified mber before the end facility policy on 15 a.m., titled nge of Condition," evised 3/10 [March d the following:  Id type] It is the facility that all ident condition will need to the physician ponsible party, and				ROPRIATE	
	communicated with a request promptly and/evaluation. The charge will no	to the physician for physician visit					

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Event ID: 4Y3R11

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  OF CORRECTION  155329	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	E SURVEY PLETED D/2012		
	PROVIDER OR SUPPLIER  ALK VILLAGE AT INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE  1302 N LESLEY AVE INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	notified that there has been a change in the resident's condition and what steps are being taken."  This Federal tag relates to Complaint IN00117328.						
	3.1-5(a)						

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Event ID: 4Y3R11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329		(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  (X3) DATE SURVEY COMPLETED 10/10/2012			
	PROVIDER OR SUPPLIE		1302 N LESLEY AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	HIGHEST WELL Each resident m must provide the services to attain practicable phys psychosocial we the comprehens care.  Based on receinterview the ensure a reside fracture, the rimmediate calculation of the for possible in caused a delatevaluation for admitted residuassessment at 7. [Resident Findings including the caused on Diagnoses including the difference of the caused on Diagnoses including the difference of the caused to difference on Diagnoses including the caused	ust receive and the facility enecessary care and or maintain the highest ical, mental, and III-being, in accordance with ive assessment and plan of ord review and facility failed to lent received re and services, in that ent fell and sustained a nursing staff failed to notify the resident's the results of the x-ray intervention and y in treatment and r 1 of 3 recently dent's reviewed for and falls in a sample of "A"].	F0309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING It is to practice of this provider to ensist that all alleged violations involved providing care/services for highest well being are provided accordance with State and Federal law through establish procedures. What corrective action(s) will be taken for the residents found to have been affected by the deficient practice? The resident no longe resides in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in the fact have the potential to be affect by the alleged deficient practice. All licensed nurses will be re-educated on MD and family notification of change in conditimeliness of notification, and machine check frequency by the SDC or designee by 10/18/12. What measures will be put in place or what systemic.	sure ving d in ed Dse n ger I l l l l l l l l l l l l l l l l l l

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Event ID: 4Y3R11

Facility ID: 000222

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155329	B. WIN			10/10/2012
NAME OF E	PROVIDER OR SUPPLIEF		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLITEER	X.		1302 N	LESLEY AVE	
ROSEWA	ALK VILLAGE AT IN	NDIANAPOLIS		INDIAN.	APOLIS, IN 46219	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	joints (ankle a	and feet), and sleep			changes will you make to ensure that the deficient	
	apnea. These	diagnoses remained			practice does not recur? All	
	current at the time of the record review.				licensed nurses will be	
					re-educated on MD and family	,
	l teview.				notification of change in condit	
					timeliness of notification, and f	
	The record indicated the resident				machine check frequency by to SDC or designee by 10/18/12	ne
	was admitted	to the facility on			The facility will in-service nursi	ing
	09-24-12.	-			and nurse management staff of	_
					fax machine document review	
		D. M.			Licensed nurses will be require	
		ne Progress Notes			to complete hourly checks of the fax machine to monitor for any	
	dated 09-24-1	2 for 11:00 p.m.			x-ray results requesting family	
	(recorded as I	Late Entry on			and physician notification. DN	
	09-25-12 at 03	2:00 a.m.) indicated			and IDT will review clinical	
		· · · · · · · · · · · · · · · · · · ·			records to ensure family and	
	the following:	•			physician notification of any significant change Monday	
					through Friday. The weekend	
	"Writer found	l resident sitting on			supervisors will perform this	
	the floor next	to bed, asked what			review on Saturday and Sunda	ays.
		s [resident] was trying			How the corrective action(s)	
					will be monitored to ensure t	
		se the bathroom and			deficient practice will not rec i.e. what quality assurance	ur,
	tell on the floo	or. ROM [range of			program will be put into plac	e?
	motion] is Wi	NL [within normal			Physician/family notification C	l l
	limits] to both	upper and lower			audit tool will be completed on	ce
	_	akness and discomfort			weekly x4, bi-weekly x2, and the	
	· ·				monthly thereafter by the DNS	or
		emity. Resident			designee. Physician/family notification CQI audit tool will t	ne
		no injury at this time,			reviewed monthly by the CQI	
	denies hitting	head. Resident			Committee for 6 months after	
	_	to bed with three staff			which the CQI team will	.
ı		lain of hip pain at this			re-evaluate the continued need	
	_				for the audit. If threshold of 95 is not achieved an action plan	l l
	i ume. MD [M	[edical Doctor]			be developed to ensure	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL		
		155329	B. WIN			10/10/	ZU 1Z	
NAME OF P	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP CODE			
ROSEWA	ALK VILLAGE AT IN	JDIANAPOLIS		1302 N LESLEY AVE INDIANAPOLIS, IN 46219				
					711 OE10, 111 402 10		avs)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE	
	notified and x	-rays ordered. Call			complianceDeficiency in this			
	light is within reach, will continue				practice will result in disciplinal	ry		
	to monitor."	reach, will continue			termination of the responsible	action up to and including		
	to momtor.				employee. Date of Compliance	)		
	The record indicated the local area				10/18/12			
		company came to the						
	1 .	erformed the x-ray as						
	ordered.							
	Review of the x-ray results, dated							
	09-25-12 and	faxed [facsimile] to						
		2:37 a.m., indicated						
	· ·	obese pt. [patient] left						
	_	antric fracture of the						
	left femur."	and it macture of the						
	lett lemut.							
	F 1 0							
		er the nurse received						
		the x-ray the nurse						
	indicated the f	following in the						
	clinical record	l:						
	Progress notes	s, dated 09-25-12 at						
	•	e created 09-25-12 at						
		licated MD updated						
	_ ·	he "L" [left] hip x-ray						
		ren to send patient to						
		gency room] for						
	evaluation."							

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Event ID: 4Y3R11

Facility ID: 000222

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER: 155329	A. BUILDING 00		00	COMPLETED 10/10/2012	
		100020	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	10/10/20	012
NAME OF PROVIDER OR SUPPLIER					LESLEY AVE		
ROSEWALK VILLAGE AT INDIANAPOLIS			INDIANAPOLIS, IN 46219				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG				CROSS-REFERENCED	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE '	COMPLETION DATE
	Progress notes, dated 09-25-12 at						
	7:00 a.m. [date created 09-25-12 at						
	7:42 a.m.], indicated "[Name of						
	family member] called and updated						
	on resident's status and being						
	transferred to	the ER for					
	evaluation."						
	Interview on 1	10-09-12 at 8:22 a.m.					
	a concerned family member indicated, "[Resident] had been in						
		-					
	the hospital previously and was considered a fall risk. When						
	[resident] was admitted [resident]						
	was concerned the floors were						
	slick. We were assured someone						
	would be available to help with						
	going to the bathroom and that sort						
	of thing and someone would be						
	with [resident] at all times.						
		d the fall occurred					
		p.m. or 11:45 p.m. the					
		ion. [Resident]					
	•	lent] head and broke					
		They didn't call me					
	until the next						
		already transferred to					
	the hospital."	•					
	•						

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, in the second		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
155329		B. WING			10/10/2012		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ROSEWALK VILLAGE AT INDIANAPOLIS			1302 N LESLEY AVE INDIANAPOLIS, IN 46219				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Let a priory or 10, 10, 12 at 10,45			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG			+	TAG DEFICIENCY)		DATE	
	Interview on 10-10-12 at 10:45						
	a.m. the Director of Nurses						
	indicated "[Resident] fell and						
	[resident] was own responsible party. An assessment was done and						
	1 2	ad some minor					
		The nurse [licensed					
		e employee #8]					
	•	octor and got an order					
	for an x-ray. Range of Motion was						
	done and everything was within						
	normal limits.	The nurse notified					
	the family member before the end						
	of his shift."						
	Review of the job description on						
		15 a.m., for "Charge					
		on Description" and					
		5 indicated the					
	following:						
	HOLD O LA DAZ	OF BOGIFFON					
		OF POSITION					
		" [bold type and					
	_	- As a member of the					
	•	ry team, the Unit					
	_	assumes planning, and accountability					
	1	•					
	for resident care of a designated unit for one shift and in accordance						
	unit for one st	int and in accordance					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	(X3) DATE SURVEY  COMPLETED			
	155329	A. BUILDING		10/10/2012			
		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIER	1302 N LESLEY AVE					
ROSEW	ALK VILLAGE AT INDIANAPOLIS	INDIANAPOLIS, IN 46219					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE			
	with Federal and State regulations						
	and company/facility policies,						
	procedures and care plans."						
	r						
	"ESSENTIAL POSITION						
	FUNCTIONS" [bold type and						
	underscored] - Clinical:						
	Immediately informs the resident,						
	consults with physician, and						
	notified the designated family						
	member and/or legal representative						
	when there is an accident involving						
	an injury which has potential for						
	physician intervention; a significant						
	change in the resident's physical,						
	mental, or psychosocial status; a						
	need to alter treatment significantly						
	or a decision to transfer or						
	discharge from the facility or						
	change roommate/room of the						
	resident."						
	This Federal tag relates to						
	Complaint IN00117328.						
	3.1-37(a)						
			l	l .			

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